SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

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Index No.

KENWELL GARDENS, LLC,

Petitioner,

VERIFIED PETITION

-against-

NEW YORK STATE DEPARTMENT OF HEALTH and HOWARD M. ZUCKER, M.D., as Commissioner of Health of the State of New York,

Respondents.

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Petitioner, Kenwell Gardens, LLC ("Kenwell"), by its counsel Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP, as and for its verified petition against respondents, New York State Department of Health and Howard M. Zucker, M.D., as Commissioner of Health of the State of New York (collectively "Respondents" or "DOH"), alleges as follows:

NATURE OF THE ACTION

1. This proceeding arises out of a clear overreach by the DOH, who is revoking the license of Kenwell and shutting down the facility known as Oakwood Senior Living ("the Kenwell Facility"), an adult care facility licensed by the DOH located in Kenmore, New York, which houses 102 residents, many of whom suffer from mental illnesses, all without providing any opportunity or hearing for Kenwell to challenge the DOH's arbitrary and capricious decision.

2. In a purported emergency order issued by the DOH on or about May 17, 2019, the DOH stated that residents were in "imminent danger" and immediately suspended Kenwell's operating certificate for sixty days and ordered the residents of the Kenwell Facility to be transferred to other facilities by May 31, 2019. (A copy of the Order is annexed hereto as Exhibit A). However, the actions of the DOH belie the finding that there is any "imminent danger" to the facility's residents.

3. The DOH's original survey of the facility concluded in December 2018, meaning that Kenwell has been operating the facility for six months since the purported violations that led to a finding of "imminent danger" were first identified. It then took nearly three weeks between the DOH concluding its second survey of the Kenwell Facility and issuing the "emergency" order effectively shutting down the facility. Moreover, despite the fact that pursuant to the emergency order Kenwell's operating certificate was suspended immediately, the DOH knowingly continued to allow Kenwell to operate the facility for approximately two weeks. In fact, that time frame is likely to be significantly longer because the DOH has recognized that transferring residents in a two-week period is unmanageable and is allowing Kenwell to treat the residents if and until an alternate facility can be found.

4. The DOH has not taken steps to appoint an operator or receiver to immediately manage and operate the facility, despite numerous overtures by Kenwell to have such a receiver appointed.

5. Thus, despite the purported "imminent danger" to the residents, the DOH has moved slowly and allowed Kenwell to continue to operate the facility and treat its residents for at least a month since the conclusion of its second survey and six months since the conclusion of its original survey.

6. During that time, Kenwell has taken tangible and effective steps to remedy the deficiencies identified by the DOH, which revolve around Kenwell's purported failure to properly provide medications to its residents and to maintain accurate medication records for its residents. Kenwell has recently hired new pharmaceutical director to help ensure compliance with all relevant statutes and to ensure that residents are receiving their proper prescribed medications and that the medication records are current and accurate.

7. In simple truth, the individuals most likely to be adversely affected by the DOH's arbitrary determination to close the facility are the Kenwell Facility's residents, many of whom have been diagnosed with mental disorders such as bipolar disorder and schizophrenia.

8. Those residents, who have found a home at the Kenwell Facility and who have bonded with the facility's staff and other residents, are immediately threatened with being forcibly transferred to other facilities, which could be long distances from the Kenwell Facility and which may not be willing or able to handle the care that these residents require, both because they are unwilling to provide the necessary care, and because almost all of the costs associated with these residents are reimbursed through SSI at significantly lower rates than residents who are

private payor, with the difference being thousands of dollars a month per resident in payments to the facility. Kenwell has significant experience dealing with these residents and provides a nurturing, stable and familiar environment for these residents.

9. There is currently no "imminent danger" to Kenwell's residents, but there is imminent harm to the Kenwell Facility, its residents and its employees if the DOH's draconian and unappealable order is allowed to stand, the facility is shut down, and its residents are uprooted and transplanted from the facility they are comfortable in and familiar with.

VENUE

10. Venue in Albany County is proper pursuant to CPLR 506(b) as it is the county in which the respondents made the determination complained of and/or where the material events otherwise took place.

THE PARTIES

11. Petitioner, Kenwell Gardens, LLC, is a limited liability company organized under the law of the State of New York, which since 2016 has been the certified operator of Oakwood Senior Living, an adult care facility located at 3456 Delaware Avenue, Kenmore, New York 14217.

12. Respondent New York State Department of Health is the department of the New York State government responsible for, among other things, the oversight of adult care and assisted living facilities in New York.

13. Respondent Howard A. Zucker, M.D., is the Commissioner of Health of the State of New York and signed the emergency order at issue in this proceeding.

STATEMENT OF FACTS

The Kenwell Facility

14. The Kenwell Facility is an adult care facility located in Kenmore, New York, Erie County. Adult care facilities provide long-term, non-medical residential services to adults who are substantially unable to live independently due to physical, mental, or other limitations. More than forty of Kenwell's approximately one hundred residents suffer from mental conditions, including bipolar disorder and schizophrenia. The Kenwell Facility also has a 16-bed assisted living program for residents who require a higher level of care.

15. The Kenwell Facility employs more than forty staff members whose job it is to provide around the clock service and care to its residents.

16. Kenwell is licensed by the DOH and its staff has extensive experience handling those residents with mental disorders.

The DOH Inspections and Kenwell's Ongoing Response

17. In October 2018, the DOH conducted a survey of the Kenwell Facility, which took place between October 31 and December 15, 2018.

18. Beginning on April 16, 2019, the DOH conducted a follow up survey of the Kenwell Facility which concluded on or about April 30, 2019.

19. Following the conclusion of that inspection, the DOH determined there were violations in the area of medication management, pursuant to 18 NYCRR § 487.7(f), including in purportedly failing to ensure the availability of the resident's prescribe medications and failing to maintain accurate and complete medication records for its residents.

20. An inspection report, dated April 30, 2019, was issued to the facility on or about May 3, 2019; although, no immediate action was taken.

21. Following the conclusion of the inspections and the issuance of the inspection report on May 3, 2019, Kenwell took immediate steps to upgrade its pharmaceutical management and record keeping systems to ensure compliance with the relevant statutes and regulations and the proper and necessary care for the Kenwell Facility's residents.

22. For instance, scheduled and "as needed" (PRN) medication scripts were obtained for the Kenwell Facility's residents and used to verify correct medications, scheduled times and doses for its residents. The correct active scripts were then placed in specific resident charts.

23. Any scheduled medications for which scripts were unable to be obtained due to the pharmacy who was servicing the Kenwell Facility switching to a new internal computer system were researched through medical visit documentation.

24. A new medication list for every resident was faxed to the primary care physician's offices for each resident for a final reconciliation of each office's

prospective residents. Any request for signing of a medication list and any needed change to the scripts was to be sent back to Kenwell.

25. This process was completed by a Registered Nurse and Pharmacist.

26. Most medication reconciliations have been returned to Kenwell while some continue to come in. Thus far, there have been very minimal changes requested to the medication lists and, in fact, most changes have been for treatments that were "PRN" medications, or medications that are taken "as needed," with the changes being that residents were no longer required to take these "PRN" medications.

27. Once these reconciliations and any needed changes are returned to the Kenwell Facility, they are verified by a registered nurse (RN) or a licensed practical nurse (LPN) and changes are made to current Medication Assistance Records (MAR) for accuracy.

28. The primary care nurse who provides care for a large percentage of the residents has completed the medication reconciliations and returned them to the facility and is pleased with the response by Kenwell and the additional measures undertaken to ensure proper resident care.

29. On an ongoing basis, once these reconciliations have been received existing resident charts are being updated, Kenwell is obtaining all medication scripts and new signed active medication lists are being placed in resident's charts after being checked for needed changes by the RN and the LPN.

30. A pharmacist from Heath Direct Pharmacy Services, a company hired to provide management solutions and optimize the Kenwell Facility's pharmacy operations to make them safer and more efficient, has completed a MAR audit to ensure all needed medications are in the facility and is conducting ongoing audits to ensure compliance. Kenwell is contracted with Heath Direct Pharmacy Services so that the facility will have now and going forward additional oversight, auditing and staff training.

31. Kenwell has also retained an LPN as a new medication director, A'Diamond Hinton, who comes with experience with medications and supervisory experience. A copy of Ms. Hinton's resume is annexed hereto as Exhibit B.

32. The DOH has been advised of the ongoing process to customize and update Kenwell's operations and medication management systems to ensure compliance with all statutes and regulations. A copy of an email from Kenwell's principal to the DOH informing the DOH of all of these changes is annexed hereto as Exhibit C.

The DOH's Arbitrary and Capricious Emergency Order

33. Throughout May 2019, there has been continuous dialogue between Kenwell and the DOH to ensure adequate prescription management services and care for Kenwell's residents and ongoing compliance with the relevant regulations.

34. Indeed, as early as May 2, 2019, Kenwell proposed the appointment of a receiver if the DOH wanted one to ensure compliance and if it was in the best interests of the residents.

35. To that end, on May 17, 2019 at 3:00 p.m., current counsel for Kenwell spoke with members of the DOH, including Heidi Hayes, the Acting Director for the Division of Adult Care Facilities and Assisted Living Surveillance, and Al Salinero, an attorney for the DOH.

36. Ms. Hayes and Mr. Salinero were notified that all interested parties were prepared to assist the DOH in taking any steps necessary to ensure that the facility was operating in a compliant and efficient manner and was providing adequate care for its residents.

37. During that call, the subject of having a receiver appointed to run the Kenwell Facility was discussed, and it was made clear that all parties were fully on board with the appointment of a receiver to immediately run and operate the facility if the DOH so required.

38. The DOH expressly represented that they were not going to shut down the facility immediately, that they were open to the appointment of a temporary receiver but that they would not wait for weeks to find an acceptable receiver.

39. However, unbeknownst to Kenwell, on that same day, May 17, 2019, the DOH issued the "Commissioner's Emergency Order" (the "Order") which was received by Kenwell on May 20, 2019, and is the subject of this proceeding.

40. The Order stated that as a result of Kenwell's purported violations of 18 NYCRR § 487.7(f), which relate to medication management, the DOH "will seek to revoke the facility's operating certificate through service of a Notice of Hearing and Statement of Charges pursuant to Social Services Law § 460-d(4)."

41. Social Services Law § 460-d(4)(b) provides, in part, that "[n]o operating certificate shall be revoked, suspended or limited without a hearing held in accordance with procedures established by [DOH] regulations."

42. However, no such opportunity for a hearing was provided to Kenwell and the DOH has not yet taken any steps to revoke Kenwell's license.

43. Instead, the DOH found, without any stated reason or rationale, that the purported violations "constitute an imminent danger to the health, safety and welfare of facility residents."

44. Thus, the Order further provided, *inter alia,* that the "operating certificate issued to [Kenwell] to operate the facility is hereby suspended for sixty days, pursuant to Social Services Law § 460-d(4)(b)."

45. Despite this immediate suspension based on purported "imminent danger" to Kenwell's residents, a temporary operator or receiver was not appointed, and the immediate transfer of the residents was not ordered, as is provided for under Social Services Law § 460-d(4)(b).

46. Instead, the DOH allowed Kenwell to continue to operate the Kenwell Facility for a period of two weeks.

47. The Order provided that transfer of all residents "shall be completed by no later than May 31, 2019."

48. Even that time frame proved illusory and far understates how long Kenwell will actually provide care to its residents. In an email dated May 25, 2019, Heidi Hayes of the DOH sent edits to a letter Kenwell proposed to send to family

members or guardians of the residents, and reflected that the notification of residents of this transfer would not be sent until May 28, 2019. The letter which Ms. Hayes provided edits to further stated that meetings with the family or guardian would not take place until June 3, 2019. (A copy of the email and letter are annexed hereto as Exhibit D). Even after that meeting, which is a requirement before any transfers can take place, it will likely take weeks (or more) for facilities to be found that are suitable for each of the residents and are willing to accept those residents. Thus, the DOH has sanctioned Kenwell's continued care of its residents for a period at least well into June. This again belies any purported "imminent danger" to the residents.

49. The Order also stated that Kenwell "shall immediately transfer all records concerning the operation of the Facility" to the DOH, but subsequently stated that no immediate transfer of these records to the DOH was necessary while Kenwell continued to provide care to its residents and seek transfers to new facilities.

50. Not once from the time that the DOH first surveyed the facility in October 2018 through the date of the issuance of the Order had the DOH ever expressed that Kenwell's residents were in "imminent danger."

51. After Kenwell received the Order, it continued to have conversations with the DOH about the appointment of an acceptable operator or receiver to operate the Kenwell Facility. All suggestions for appointment of an operator or

receiver were rebuffed by DOH without explanation, leaving Kenwell to continue operating the facility.

52. The DOH's actions in effectively revoking Kenwell's license, shutting down the Kenwell Facility, and directing the relocation of its residents without any opportunity for a hearing constitute arbitrary and capricious actions and evidence bad faith by the DOH.

53. Indeed, the DOH's actions here demonstrate that there was no "imminent danger" to the residents, which was the stated reason for DOH's immediate suspension of Kenwell's license and ordering the residents to be transferred.

54. DOH's original survey of the facility inspection of the Kenwell Facility took place from October 31 through December 15, 2018. The Commissioner's Emergency Order cited that survey as a basis to find "imminent danger" to residents, yet that survey took place nearly six months before the Emergency Order was issued, during which time Kenwell provided care for the residents.

55. DOH's second survey of the Kenwell Facility concluded at the end of April 2019. The Order was not issued until nearly three weeks later, which hardly constitutes any imminent action.

56. Moreover, the Order did not immediately appoint a receiver or order the immediate transfer of residents, which the relevant statutes provide for, as the Order still allowed Kenwell until May 31, 2019 to find alternate facilities for its residents. Thus, the DOH has allowed Kenwell to care for and treat all of the

residents that are purportedly in "imminent danger" for over a month. Even then, the DOH has extended that deadline by sanctioning the initial meeting between Kenwell and family members or guardians for the residents to take place on June 3, 2019, with full knowledge that it might be weeks after this meeting that transfers can take place.

57. The residents of the Kenwell Facility are the individuals who will suffer imminent and irreparable harm if the Order is allowed to be implemented.

58. As noted, a large percentage of the residents have mental disorders. Additionally, care for these residents is almost always paid for and reimbursed through SSI, which provides for far less reimbursement to facilities than through a private payor resident, with the difference being thousands of dollars a month in reimbursement. Thus, many facilities are both unable and unwilling to accept the type of residents that Kenwell houses.

59. Those residents are now in imminent danger of being uprooted from a facility that is effectively their home. Moreover, the DOH has provided no support in locating suitable facilities that can manage and care for these residents' needs and/or are willing to accept residents. Indeed, the only support that DOH provided was an email attaching a spreadsheet showing facilities with open spots for residents in Erie County. The DOH made no efforts to indicate or determine whether any such facility would actually accept Kenwell's residents. Moreover, by including information only for Erie County facilities, the DOH ignored facilities in

adjoining counties that may be closer to the Kenwell Facility and thus more suitable and convenient for Kenwell's residents and their family members/guardians.

60. Instead, the residents may be forced to relocate to facilities which are not located in close proximity to the Kenwell Facility, and which do not have the experience or willingness to handle and care for these residents.

AS AND FOR A FIRST CAUSE OF ACTION
(Declaratory Judgment)

61. Kenwell repeats and re-alleges each of the foregoing allegations as though fully set forth hereat.

62. There exists a justiciable controversy between the parties based on the DOH's actions to immediately suspend Kenwell's license and ordering the transfer of all Kenwell's residents to different care facilities.

63. The DOH's actions are arbitrary and capricious and have been undertaken in bad faith.

64. Specifically, the DOH's actions evidence that there is no "imminent danger" to the residents because the DOH has allowed Kenwell to continue to operate the Kenwell Facility for more than five months following its initial inspection of the facility in 2018.

65. Moreover, after its subsequent inspection of the Kenwell Facility in April 2019, the DOH waited nearly three weeks before issuing the Order which found "imminent danger" to the residents.

66. Between April 2019 and the issuance of the Order on May 17, 2019, the DOH expressly represented that it would not immediately suspend the license

of Kenwell or shut down the facility while the parties sought a receiver or operator to manage the facility.

67. Those express representations were false and were made in bad faith by the DOH.

68. As subsequently demonstrated by the DOH's actions, DOH had no intention to consider any reasonable alternative operators or receivers and were interested only in shutting down the Kenwell Facility without any proper hearing, and without any regard for the safety and well-being of Kenwell's residents or the livelihood of the employees of Kenwell.

69. Accordingly, Kenwell seeks a declaration pursuant to CPLR 7803 that the DOH's Order and actions were arbitrary, capricious and an abuse of discretion.

AS AND FOR A SECOND CAUSE OF ACTION
(Preliminary and Permanent Injunction)

70. Kenwell repeats and re-alleges each of the foregoing allegations as though fully set forth hereat.

71. Kenwell seeks injunctive relief based on the DOH's actions in arbitrarily and capriciously suspending its license and ordering the transfer of the residents of the Kenwell Facility to alternate facilities without notice or chance for a hearing.

72. Kenwell is likely to succeed on the merits of its claim because the DOH's purported finding of "imminent danger" to the residents of the Kenwell Facility is unsupported by the facts and belied by DOH's own actions.

73. As described above, DOH's original survey of the facility inspection of the Kenwell Facility took place from October 31 through December 15, 2018. The Commissioner's Emergency Order cited that survey as a basis to find "imminent danger" to residents, yet that survey took place nearly six months before the Emergency Order was issued, during which time Kenwell provided care for the residents.

74. Additionally, the DOH has allowed Kenwell to operate the facility and care for its residents for a month between the time that it completed its second inspection of the facility and the time it required residents to be transferred based on the terms of the Order.

75. Even after the issuance of the Order, the DOH still allowed Kenwell to operate the facility and care for the residents for two weeks without the appointment of a temporary operator or receiver, despite the regulations providing for the appointment of such operator or receiver in cases involving "imminent danger" to residents.

76. Kenwell and its residents will suffer irreparable harm absent an injunction because Kenwell's license will be effectively revoked without a hearing, the facility will be closed, and the residents will be transferred to facilities not of their choosing, which are likely not in close proximity to the Kenwell Facility and which are unable or unwilling to provide the necessary care to these residents.

77. The balance of equities favors granting the injunction staying implementation of the Order because there is no imminent danger to the residents

and the status quo will be maintained while Kenwell is afforded an opportunity to a proper hearing on revocation of its license.

78. There is no adequate remedy at law.

WHEREFORE, Kenwell requests a judgment against the respondents as follows:

A. On its First Cause of Action, declaring pursuant to CPLR 7803 that the Order and the DOH's actions were arbitrary and capricious and an abuse of discretion;

B. On its Second Cause of Action, a permanent injunction enjoining and staying the enforcement of the Order;

C. On all causes of action, awarding such other and further relief as the Court may deem just and proper.

Dated: May 29, 2019

ABRAMS, FENSTERMAN, FENSTERMAN, EISMAN, FORMATO, FERRARA, WOLF & CARONE, LLP

By: _____

Matthew F. Didora
3 Dakota Drive, Suite 300
Lake Success, New York 11042
(516) 328-2300
mdidora@abramslaw.com

Attorneys for Petitioner

VERIFICATION

STATE OF NEW YORK)
) SS.:
COUNTY OF NASSAU)

BRIAN ROSENMAN, being duly sworn, deposes and says:

I am a principal of the petitioner in the within action. I have read the foregoing Verified Petition and know the contents thereof, and the same is true to the best of my knowledge, except as to those matters therein stated to be alleged on information and belief, and as to those matters, I believe them to be true.

BRIAN ROSENMAN

Sworn to before me this
29 day of May, 2019

Notary Public

MANLUO MIAO
Notary Public - State of New York
NO. 01MI6377221
Qualified in Nassau County
My Commission Expires 06/25/22